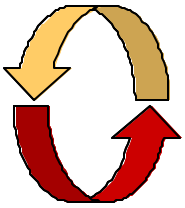
Aging & Disability Resource Centers



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An Annotated History of Wisconsin's Aging and Disability Resource Centers

October 24, 2003

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An Annotated History of Wisconsin's Aging and Disability Resource Centers

This paper summarizes the Wisconsin Resource Center (RC) experience as documented in The Lewin Group's four reports for the Wisconsin Legislative Audit Bureau's Evaluation of the Family Care Program. The complete reports appear on the Wisconsin Family Care Web site at http://www.dhfs.state.wi.us/LTCare. This report provides background for the special HCBS Waiver Conference AoA-CMS Aging and Disability Resource Center grantee add-on session with the Wisconsin RC Directors. The WI RC Directors will elaborate further on their experiences and operational considerations.

WHY RE-DESIGN THE LTC SYSTEM?

Wisconsin's Family Care pilot program constitutes a major re-design of the state's long-term care (LTC) system. Concerns over system fragmentation, institutional bias, and rising expenditures fueled a strong desire in Wisconsin to improve and redesign the system. The stated goals of Family Care include:

- Giving people better choices about where they live and what kinds of services and supports they get to meet their needs.
- Improving access to services.
- Improving quality through a focus on health and social outcomes.
- Creating a cost-effective system for the future.

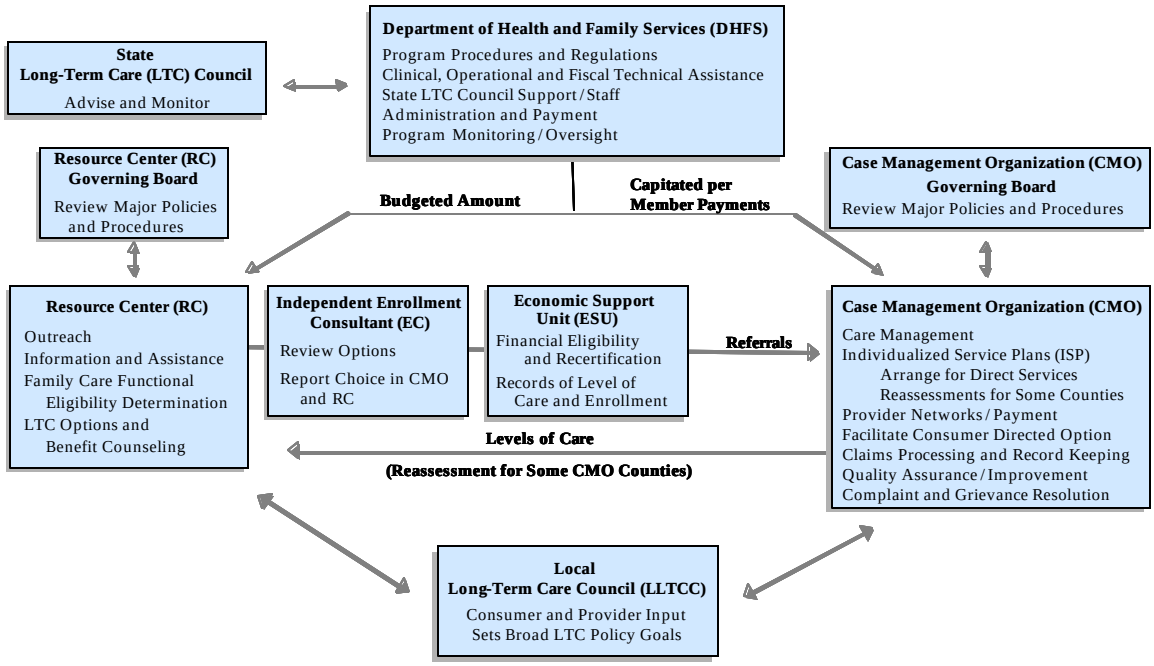
Family Care required pilot counties to initiate two new entities – a single entry point Resource Center (RC) and, for a subset of the counties, a Care Management Organization (CMO). The RCs, currently in nine counties, addressed fragmentation by streamlining eligibility and information channels through a single entry point for multiple target populations (older adults and individuals with developmental and physical disabilities)[1]. Stakeholders also wanted to reduce unnecessary institutionalization by expanding home and community-based services ensuring consumer choice, quality, and flexibility of services. RCs offered an avenue for disseminating information about home and community-based services to members of the target population and their caregivers. The availability of such information has the potential to prevent unnecessary institutionalization and ensure future sustainability of state LTC programs by encouraging individuals to plan for LTC needs. The implementation of a managed care model, county-based Care Management Organizations (CMO), currently in five of the counties, offered flexible services and an ability to control spending.

STRUCTURE OF WISCONSIN RE-DESIGN

Exhibit 1 displays the major entities involved in the Wisconsin Family Care Model and provides a brief explanation of their roles.

[1] Milwaukee's Resource Center currently serves only individuals age 60 and older.

Exhibit 1
Important Entities in the Family Care Model



Note: County Economic Support Units fall under the State Department of Workforce Development

A. Resource Centers (RCs)

County RCs offer a variety of services, including one-stop shopping for older adults, people with disabilities, and their family members for a wide range of information and providers in the local communities. In addition, the RCs provide counseling about long-term care options and eligibility determination for the Family Care benefit. The model builds on the Older Americans Act senior information and assistance program by offering a seamless flow for consumers to link to Medicaid and other program eligibility.

Services such as referral and options counseling are available to all members of the county at any income or functional level. This serves a prevention function by encouraging people to plan for long-term care and support family caregivers so they will be able to care for relatives longer in the community thereby potentially curbing the drain on State dollars, nursing facility care funded by Medicaid. The RCs also serve as a clearing-house of information designed to assist service personnel working with populations in need of long-term care services. Services are provided via telephone, home visits, and Web sites.

B. Care Management Organizations (CMOs)

CMOs, county care management organizations, receive per member per month payments to deliver services to individuals receiving the Family Care benefit.[2] The CMOs must develop a provider network sufficient to provide services to the target populations enrolled in Family Care in their respective counties. CMO staff perform comprehensive interdisciplinary assessments of consumer needs and preferences and work with consumers to develop a plan of care. CMOs must also monitor quality.

C. Governing Boards

Each RC and CMO must have governing boards representative of the target populations they serve. The board for the RC must be structurally separate from that of the CMO in part to address federal concerns regarding the same entity, currently counties, being ultimately responsible for all aspects of eligibility determination and enrollment under a fiscal model that includes incentives to restrict care or possibly limit eligibility.

RC governing boards provide oversight on the development of a mission statement for the RC, determine relevant structures, policies, and procedures of the RC consistent with state requirements and guidelines, identify unmet needs, and propose plans to address unmet needs.

D. Department of Health and Family Services (DHFS)

Wisconsin's State Department of Health and Family Services oversees Medicaid and other health programs and social service programs.[3] The Department of Health and Family Services, primarily through the 25 member staff of the Center for Delivery Systems Development and with assistance from the Division of Supportive Living and the Bureau of Information Systems, oversees the program and provides extensive technical assistance to the county entities.

E. State LTC Council

The statewide Long Term Council created by statute in 1999, serves as an advisory committee to the Governor, the Legislature, and DHFS concerning Family Care, as well as the future of all long-term care programs in the state.

F. Local LTC Councils (LLTCCs)

The county-based Local Long-Term Care Councils (LLTCCs), provide general planning and oversight in counties with both RCs and CMOs. They serve as advisory bodies with the perspective of the overall long-term care system in the county. The councils were intended to meet a CMS requirement as a conduit for consumer input independent from the county. During implementation, these local councils were to ensure adequate consumer advisory input into the implementation of Family Care in their respective county. Each Council must be comprised of

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[2] To receive the Family Care benefit an individual must qualify functionally (nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF-MR) level of care) and financially (Medicaid eligibility). Cost-share options are available for individuals who do not meet financial requirements.

[3] Definition From http://www.dhfs.state.wi.us/aboutdhfs/BiennialReport9799

17 members, nine of whom represent consumers in the three Family Care target populations proportional with the number of people in those target populations receiving long-term care in the state as determined by DHFS.

G. Independent Enrollment Consultant

Beginning in January of 2002 (April 2002 in Milwaukee), counties incorporated an independent enrollment consultant (EC) into the enrollment process for the Family Care benefit to curb potential conflict of interest. The EC must be independent of the county and functions to provide unbiased information to the consumer about his or her choices. Additionally, the EC ensures the consumer's freedom of choice in enrolling with a managed care organization in order to meet a standard federal Medicaid managed care requirement. In all of the CMO counties, with the exception of Milwaukee, which offers other managed care programs such as PACE and Partnership, eligible consumers must choose between Medicaid fee-for-service and the CMO to receive publicly-supported home-and-community-based waiver services. Funding for the ECs was reallocated from the state budget for RCs.

H. Economic Support Unit

County Economic Support Units (ESU) under the State Department of Workforce Development determine financial eligibility for Medical Assistance (MA) and processes enrollment by: 1) inputting the final level of care (LOC) determination for Family Care supplied by the RC for CMO reimbursement purposes; and 2) determining cost-sharing and inputting that amount into the Client Assistance for Re-Employment and Economic Support (CARES) system. These ESU functions in the CMO counties constitute one of the many eligibility determination and ongoing tracking activities carried out by ESU staff for programs targeted to the low income population, including other non-Family Care Medical Assistance (MA), Wisconsin Works (W-2), which is Wisconsin's Temporary Assistance to Needy Families (TANF) program, the continuance of child only cases, child care assistance, and food stamps, among others. Close collaboration with the ESU proved beneficial in Resource Center operations. Some counties even chose to co-locate the RC and the ESU.

DEVELOPMENT OF WI RCS

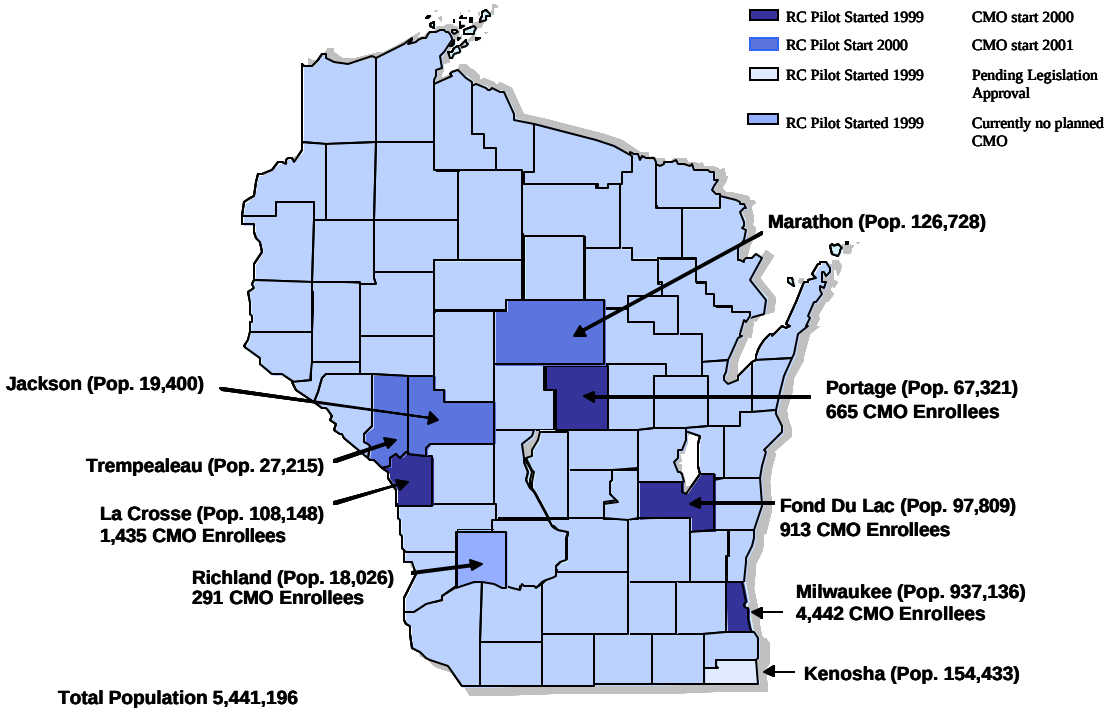
Prior to the RCs, pilot WI counties lacked a centralized source for Information and Referral (I&R) and service access. Many AAAs in Wisconsin offered information and assistance services. Under the old system, adults in need of care received funding from various state and federal sources, with differing eligibility criteria, some of them means-tested and many targeted to different populations (see ***Appendix A*** for a description of the major programs).[4]

Under the new system, those disparate funding sources were combined into the CMO capitated payment in CMO counties. In RC counties without a CMO, those programs continue to operate and the RCs counsel individuals about their available options and help guide them through the process.

[4] Request for Proposal for the Evaluation of the State of Wisconsin Family Care Program Department of Health and Family Services: RFP: LAB-1099. (1999, September). Issued by the Wisconsin Legislative Audit Bureau. Madison, WI.

Exhibit 2 offers a view of the pilot counties involved in Family Care. Five of the nine counties also have CMOs. Of the nine county Resource Centers currently operating, eight were piloted in 1999, and one in 2000. DHFS allowed for variation in Resource Center development at the county level with the exception of a standardized functional eligibility tool. ***Exhibit 3*** further displays the variation in the pilot counties in the beginning stages of the program. Three counties housed the RC within departments on aging, one used a combination of the department on aging and the public heath department, four were based on the county social or human service agencies and one split between the county social services and the developmental disabilities agency. Many of the RCs served target populations in rural areas with few minorities. Full time equivalent staff (FTEs) varied by county in relation to county population size. In 2002, the nine Resource Centers had a total of 140.6 FTEs (a 22% increase from 2001). First year contacts ranged from 2 to 3.8 per 1,000 county population. Portage exceeded that range with 9.2 potentially due to a highly visible RC in an already established senior center as well as reporting differences. More about RC contacts can be found in the section about Outreach (pg. 15).

Exhibit 2
Family Care Sites



Source: Total CMO enrollment , 7,746 as of October 1, 2003, as posted on http://www.dhfs.state.wi.us/LTCare/Generalinfo/EnrollmentData.htm and population estimates from Population Division, U.S. Census Bureau, Table CO-EST2002-01-55 - Wisconsin County Population Estimates: April 1, 2000 to July 1, 2002, Release Date: April 17, 2003

Exhibit 3
Overview of Counties at Start-up

	Total	White	Black	AI/E/A	Asian / PI	% A/PI Hmong	% A/PI Chinese	Hispanic	RC Administration	CMO Administration	FTEs 3/01	RC Contacts per 1,000 County Population
CMO Counties												
Fond Du Lac	94,329	98.7%	0.4%	0.4%	0.7%	31%		1.4%	Department of Social Services		11.80	2.10
La Crosse	102,279	95.5%	0.6%	3.6%	3.6%	73%		0.9%	Human Services Department – Long Term Support Section		8.50	2.50
Milwaukee	908,940	74.5%	24.1%	0.8%	2.1%	22%	15%	5.9%	Department on Aging		55.25	3.40
Portage	64,748	98.2%	0.3%	0.5%	.7%	30%	27%	1.3%	Department on Aging	Health and Human Services Department	5.58	9.20
Richland	17,920	99.6%	0.1%	0.2%	0.3%			0.4%	Commission on Aging	County Health and Human Services	3.00	2.60
RC Only Counties												
Jackson	17617	93.5%	0.4%	4.2%	0.2%			0.0%	Department of Health and Human Services	NA	2.52	2.70
Kenosha	142,872	93.1%	5.0%	0.4%	0.7%			5.6%	Human Services Department Elderly/PD – Division of Aging DD – Division of Disability Services	NA	13.75	3.80
Marathon	122,450	96.1%	0.5%	0.2%	2.8%	2.2%		0.5%	Marathon County Social Services North Central Community Services Commission on Aging	NA	13.00	2.30
Trempealeau	26,354	99.0%	0.1%	0.1%	0.3%			0.3%	Department of Social Services	NA	2.25	3.50

AI/EIA = American Indian/Eskimo/Aleut

PI = Pacific Islander

Note: Population source is USA Counties General Profile 1998 (includes population data for 1997 and 1996) taken from U.S Census website at http://www.census.gov/statab/USA98/55/000.txt

Hmong and Chinese percentages represent the percent of Asian/Pacific Islander

Further, all of the counties had waiting lists for Medicaid waiver programs. Counties with CMOs began eliminating waiting lists after transitioning individuals into the CMO benefit from the waiver programs. By July 2002, all CMO counties had eliminated their waiting lists. The three counties operating RCs only all experienced increases in waiver waiting lists from the beginning of the pilot in 1999 to 2002. Kenosha experienced a 110 percent increase potentially due to the promise of more benefits as the next likely CMO county. Marathon experienced a 43 percent increase and Trempeleau a 36 percent increase. This compares with a 35 percent increase in the remainder of the WI counties not participating in the RC and CMO pilot program.

SERVICES PROVIDED BY THE RESOURCE CENTERS

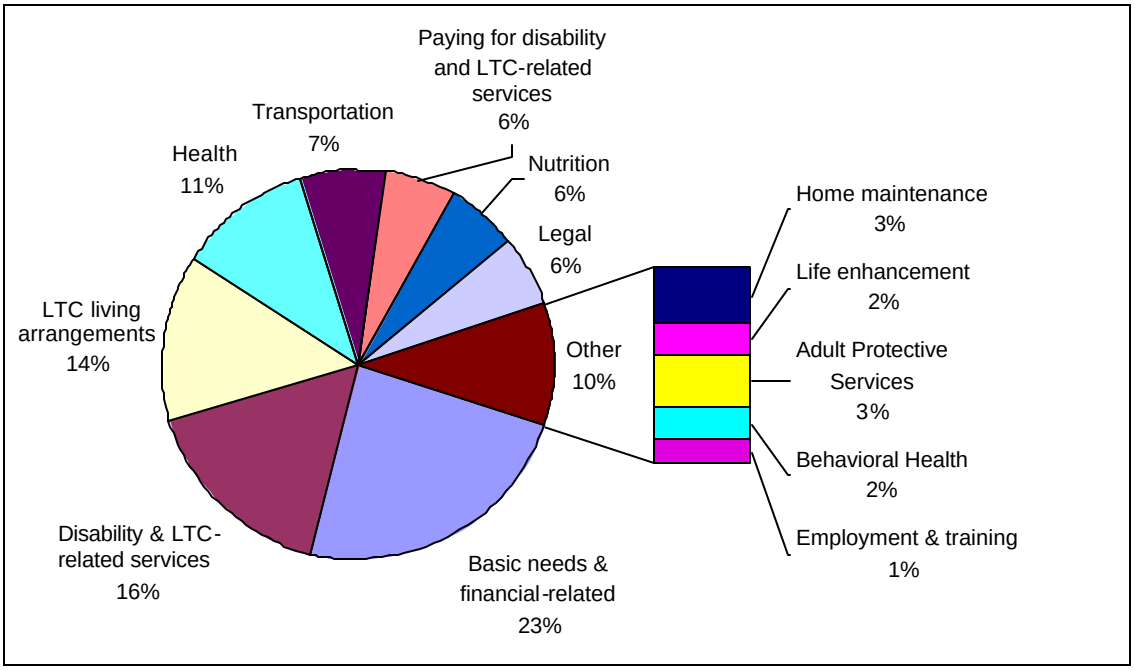
Resource Centers are required by contract to provide the following services:

- Information and assistance to the target populations, their friends, family and caregivers and the general public. The majority of information sought from RCs continues to be: 1) basic needs and general benefits, 2) disability and long-term care related services, and 3) long-term care living arrangements (***Exhibit 4***). These percentages have remained relatively constant since the beginning of RC operations.
- Long-term care counseling and advice about options available to meet long term care needs and about factors to consider in making long term care decisions to members of the target populations and their families.
- Benefit specialist services about what benefits are available to individuals based on functional or financial status. Disability Benefits Specialists (DBSs) assist adults under age 60 with disabilities while the Elderly Benefits Specialists (EBSs),which were in place state-wide through Wisconsin County Aging Units and Area Agencies on Aging prior to Family Care Resource Centers, focus on older individuals. DHFS reports that the DBS position deals with more complicated cases than the EBS due to the multiple benefits beyond Family Care available to the disabled population.
- Immediate advice and assistance in a crisis The RC acts as a triage system linking individuals in a crisis to needed services or facilitating immediate pre-enrollment into the CMO. This may include responding to a situation where someone needs a caregiver in an emergency.
- Elder abuse and APS need identification RC workers serve as a referral source for adult protective services as they make contact with older adults and family members.
- Transition assistance for young adults RCs must make an effort to make parents of children with disabilities aware of the Family Care benefit as children become eligible at age 18. Many RCs have accomplished this through outreach to the school system.
- Prevention and early intervention These include health promotion activities as public education which potentially impact the prevalence of disability. Some counties have initiated programs addressing fall risk, nutrition and/or fitness.
- Eligibility determination for the CMO benefit The RCs determine functional eligibility for Family Care, while the ESUs determine the financial eligibility with close collaboration from

the RC. A third agency, the independent enrollment consultant, offers choice counseling to help the consumer understand his or her options (see ***Exhibit 1***).

- Pre-admission counseling By statue, RCs in CMO counties had the additional responsibility of developing and implementing a Pre-Admissions Counseling (PAC) phase in plan. The CMO county RCs had to notify facilities such as hospitals, nursing homes, community-based residential facilities (CBRFs) of the requirement to make mandatory pre-admission counseling (PAC) referrals when a consumer had a long-term care need of 90 days or more. The RCs reported being overwhelmed by the number of referrals to which they had to respond, primarily from the hospitals. RC staff indicated that the majority of the hospital referrals were inappropriate, in that the individuals being referred did not have a long-term care need of 90 days or more. In response, DHFS suspended the requirement for mandatory referrals from hospitals only in the fall of 2000. Nursing homes, community-based residential facilities, residential care apartment complexes and adult family homes continue to be required to make referrals to the RCs.

Exhibit 4
Resource Center Information Requests by Category, First Quarter of 2003



Source: Quarterly Family Care Activity Report: For periods ending March 2003

Exhibit 5 provides examples of the ways in which the Wisconsin Resource Centers address awareness, assistance, and access.

Exhibit 5
Crosswalk of Wisconsin RC Sources to
AoA-CMS Grantee Awareness, Assistance and Access Requirements

Awareness	Assistance	Access
Information about LTC options and services	Options counseling	Screening and eligibility determination for Medicaid and other state or federal programs
Public education on need to plan for LTC	Benefits counseling	Linkage to private pay services (e. g. geriatric care management, home care agencies, etc.)
Prevention and early intervention	Employment counseling	One stop shopping for consumer and family members
Outreach to gatekeepers (police, fire department, postal workers, etc.)	Immediate advice and assistance in crisis	Relationships with providers
Outreach to hospitals and LTC providers	Elder abuse and Adult Protective Services (APS) need identification	
	Transition assistance for young adults	

Source: Adapted from AoA and CMS Requests For Proposal, 2003

ACCESS TO THE FAMILY CARE BENEFIT

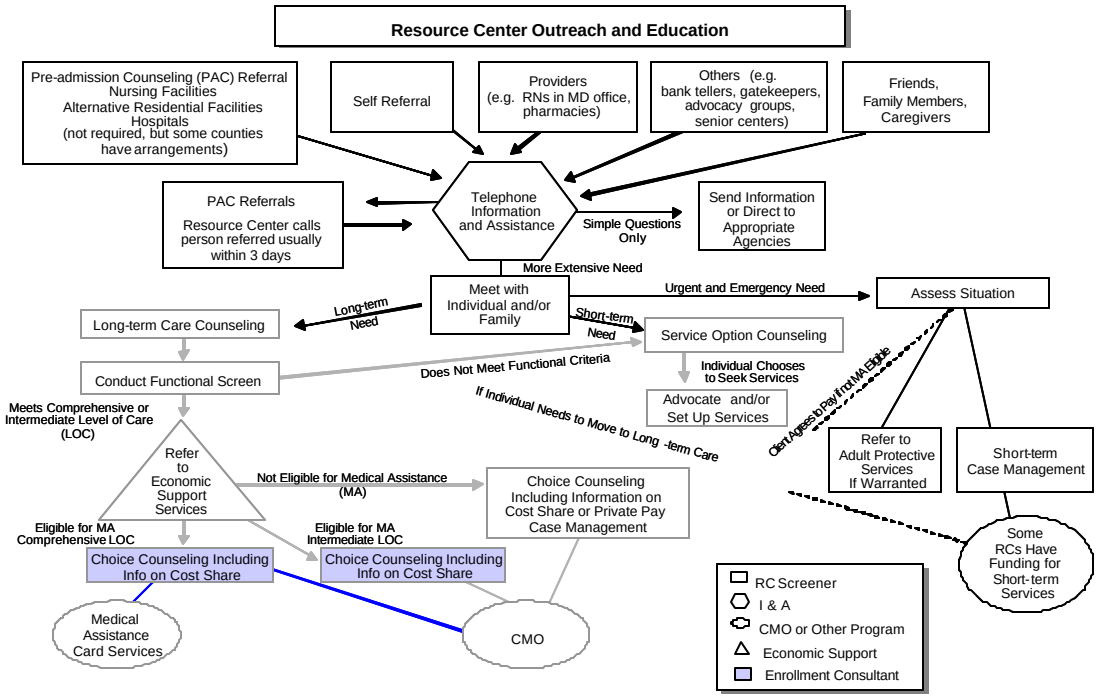
Exhibit 6 details how consumers access the Family Care benefit of the CMO through the RC. The CMO enrollment process became progressively more complicated during the course of Family Care's implementation. The original plan was to develop one-stop shopping through the RCs keeping things as simple as possible for the consumers. Practical and policy considerations prevented a true one-stop shop. The RCs provide information about the CMO, its benefits and alternatives and determine functional (or programmatic) eligibility. However, local Economic Support Units need to determine financial eligibility and any cost-share amounts and federal requirements instituted an Independent Enrollment Consultant.

Initially, ESUs did not participate in the development of the Family Care enrollment process. Once the oversight was identified, the CMO counties established regular meeting times with their ESUs to work on issues surrounding the enrollment process. All CMO counties now have ES workers specializing in Family Care-related eligibility to increase productivity and improve communication.

The single Web-based functional screen to determining programmatic (functional) eligibility for all three target populations remains one of the few standardizations DHFS required of the pilot

counties. In 2003, the functional screen was adopted statewide. The screen offers the beginning of a more comprehensive assessment that can be used to develop initial plan of care in addition to determining level of care for Medicaid. The State moved from a PC-based, dial-in upload for the functional screen, to the Web-based screen in October 2001. DHFS noted that the Web-based screen increases screener reliability by subjecting the information to cross-edits and other checks as it is entered. In addition, DHFS staff review automated system-generated reports to identify patterns of screening that might indicate questionable screening practices, such as numerous screens recorded on one person during a short time period. As a result, manipulating the screen for eligibility purposes is less likely to occur with this system.

Exhibit 6
Consumer Access to Wisconsin Resource Center and CMO Services



Note: In the enrollment broker model, choice counseling will be performed by an independent agency.

RC IMPLEMENTATION ACTIVITIES

A. Staffing and Training

The RCs' clinical tasks include providing information and assistance (I & A), conducting community outreach and prevention activities, administering the LTC functional screen, providing options counseling, and tracking demographic information about callers. Many RC workers had previously performed information and assistance responsibilities. However, for community outreach and prevention and functional screening, the RCs needed to train and hire workers. The State offered training for screeners requiring an exam to ensure competency. Staffing increased by more than 10 percent in seven of the nine RC counties in the second year from 2001 to 2002, and changed only slightly in Fond du Lac and Jackson. In 2002, staffing ranged from 2.7 FTEs in Jackson and Trempealeau (both small rural counties) to nearly 67 for

Milwaukee. ***Appendix B*** provides details on the number of full time equivalent positions in 2001 and 2002 for the nine RCs.

Disability Benefit Specialists (DBSs) represented a new position established in conjunction with the Resource Centers. The DBS has three main functions which differentiate its duties from those of an RC social worker including: (1) information provision about available benefits; (2) assistance with benefit applications; and (3) advocacy in appealing benefit denials. Social workers at the RC can complete these tasks, but the resources needed to research benefits detracts from RC outreach, I & A, and the case enrollment processes. Additionally, attorneys knowledgeable in disability law continually train and monitor DBSs. The state-wide DBS attorney, funded by General Purpose Revenue through Family Care, offers consultation to DBSs in determining appropriate interpretation of the law for benefits. ***Appendix C*** provides a sample DBS job description Lewin adapted from information provided by the pilot counties, the RC contract, and a Bureau of Aging and LTC Resources (BALTCR) commissioned report.

RC staff noted they valued the expertise of the specialist. The ability of the DBS to offer training and to provide consultation to social workers about the most current regulations regarding benefits helped to maximize social work resources. Prohibitive restrictions in information flow between RC social workers and DBSs due to legal confidentiality rules were addressed by either developing confidentiality agreements with DBS supervising attorneys or release of information processes to allow more continuity in service delivery to RC consumers.

B. Compiling Provider and Resource Information

Another major task for RCs included compiling and maintaining a list of providers by type and service. The RCs use these lists to inform consumers about their LTC options. Not all of the counties keep provider information in a comprehensive, computerized database. Some counties use lists, pamphlets, and brochures in addition to information stored electronically and/or on Web sites about providers. All the RCs maintain information about providers covering the population served (i.e., MR/DD, older adults), hours of service, and fees. Other details such as residential capacity (i.e., the numbers of beds or private rooms available) and languages spoken vary by county. Over the course of 2000 to 2003, the RCs continued to add provider information often automating and making it available to consumers directly other via Web sites.[5]

C. Outreach

By contract, RCs are responsible for identifying community needs for segments of the target population(s) that may be either unserved or underserved and types of services or facilities that may be in short supply in order to target outreach, education, prevention and service development efforts. Outreach plans have to be developed and implemented each contract year. During the initial start-up of the RCs, staff focused on establishing initial outreach and information materials and distribution points and activities for the materials.

[5] See the DHFS Family Care Web site at http://www.dhfs.state.wi.us/LTCare/Generalinfo/Where.htm#RC for links to current RC Web-pages.

Every RC provided outreach in the form of literature, such as pamphlets and brochures, which were often distributed at health fairs and other community presentations (see ***Exhibit 7***). RCs also pursued active outreach strategies. For example, the Marathon Web site provides information, linked to other service providers, online information requests, online PAC referral, a chat room, and a discussion board, thus enabling isolated persons access to information and services provided by the RC. In La Crosse, the RC served as the central contact for Neighbor Care, a program that aids businesses in identifying potential RC customers. Fond du Lac provided brochures to individuals receiving home-delivered meals, and Kenosha sent 5,000 brochures to retirees through a United Way mailing. The RCs also used the media where five RCs (Jackson, La Crosse, Portage, Richland, and Trempealeau) advertised in local newspapers, four RCs (La Crosse, Jackson, Milwaukee and Trempealeau) developed and aired television ads about the RCs services, and two RCs (Portage and Trempealeau) included radio advertisements.

Counties also experimented with different outreach strategies. Staff in Fond du Lac, for example, initiated an effort in 2002 to offer information and assistance at two senior centers on one day each month in rural areas - Ripon Senior Center and Waupun Senior Center. However, they determined that demand was insufficient and suspended the Senior Center effort. Fond du Lac and Richland also partnered with paramedics to identify potentially eligible persons.

Exhibit 7
Resource Center Outreach Activities,
April 2000 to March 2001 and April 2001 to March 2002

Outreach Strategy	Fond du Lac		Jackson		Kenosha		La Crosse		Marathon		Milwaukee		Portage		Richland		Trempealeau	
	01	02	01	02	01	02	01	02	01	02	01	02	01	02	01	02	01	02
General Public																		
RC Literature	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Directory of Services			●	●	●	●			●	●								
Community Presentations	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Presence at Health Fairs	●	●				●		●	●	●		●		●		●		●
Gatekeepers – accountants, grocery, movies, paramedics		●						●		●		●		●				
Web site	●	●			●	●			●	●	●	●	●	●		●	●	●
University/ College						●						●		●				
Media																		
Radio		●	●	●										●	●	●		●
TV Ad/ Interview Show			●	●			●	●				●					●	●
Newspaper Ads			●	●			●	●						●		●		●
Newspaper Articles	●	●		●	●	●								●		●		●

Exhibit 7
Resource Center Outreach Activities, April 2000 to March 2001 and April 2001 to March 2002, continued

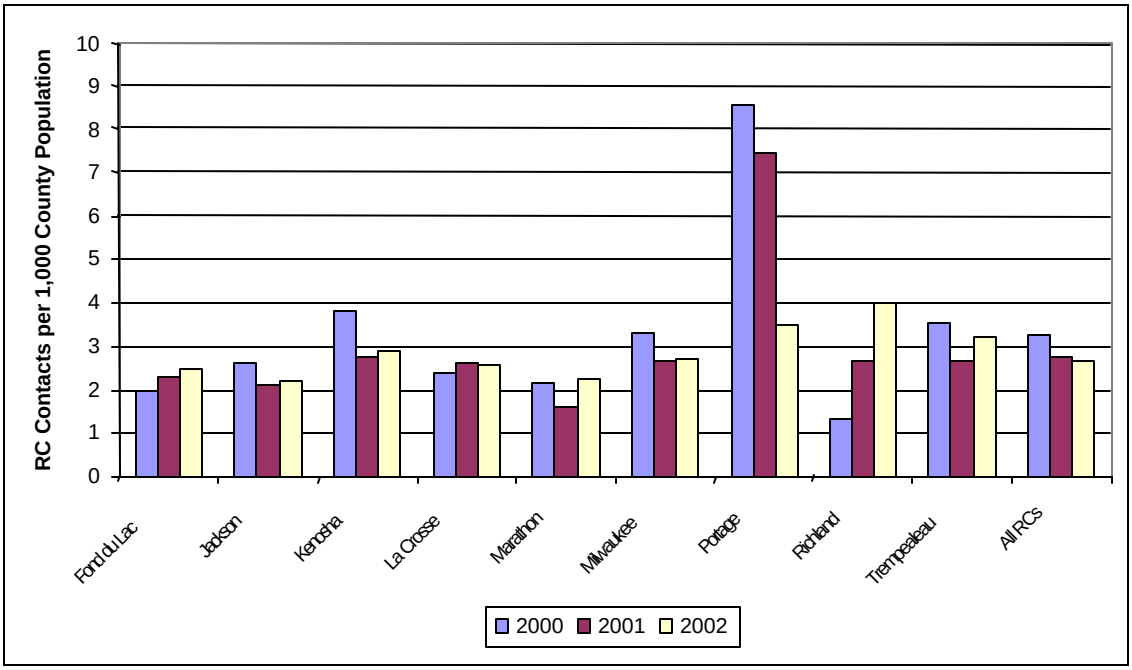
Outreach Strategy	Fond du Lac		Jackson		Kenosha		La Crosse		Marathon		Milwaukee		Portage		Richland		Trempealeau	
	01	02	01	02	01	02	01	02	01	02	01	02	01	02	01	02	01	02
Targeted Outreach																		
Flu Shots		●								●								●
Hmong Elders Focus Group							●	●										
School System	●					●	●	●								●		●
Provider Presentations (Group)		●	●					●		●					●	●	●	●
Provider Meetings (Individual)	●	●					●	●		●		●		●		●		●
Rural areas		●				●				●								

Source: Quarterly reports submitted by Resource Centers.

Collaboration with hospitals and nursing facilities offered an additional way to reach the target population. In most counties, provider compliance with the PAC referral has been less than 100 percent. The state has provided training to RCs and providers, and has urged counties to pursue higher referral rates. Counties reported that providers approached PAC as all or nothing -- either they referred all contacts or did not refer any contacts. According to RC staff, providers did not appear to make a determination regarding whether an individual would have a long term care need for 90 days or more. Most RCs do not discourage this practice because, although these contacts may not result in an immediate request for assistance, the RC will have made its services known to an individual who may call in the future.

Examining the average monthly RC contacts per 1,000 people in the counties provides an indication of the effectiveness of overall outreach. ***Exhibit 8*** shows that the average RC contacts per month for all of the RCs fluctuated over time with six of the nine RCs reporting the highest number of contacts per 1,000 county population in 2000 and all but Portage showing stability or increases between 2001 and 2002. Some of the fluctuation may represent reporting refinements over time as the RCs improved and standardized their tracking of contacts. For example, the apparent large decline in contacts in Portage resulted from the county adopting DHFS' convention for reporting that excludes pre-admission counseling referrals, whereas prior to 2002, they had included these as contacts. Richland's increase in contacts over time reflects its RC's later start-up (November 2000), compared to all the other RCs that had been operation for at least a year prior to 2000.

Exhibit 8
Average Monthly Resource Center Contacts per 1,000 County Population

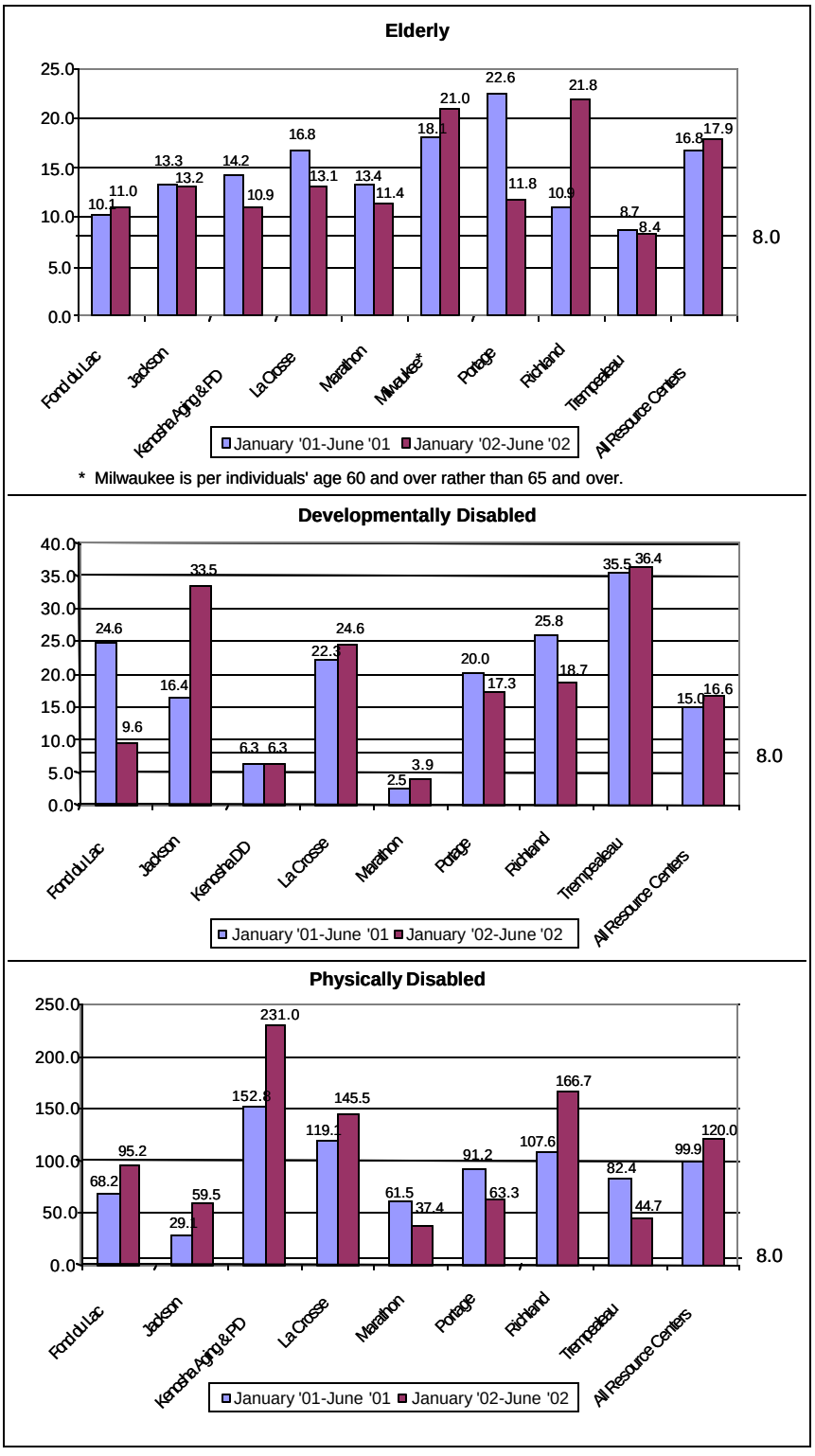


Note: Milwaukee's resource center focuses on individuals age 60 and older, however, the denominator used for county population includes all ages.

Source: The Lewin Group analysis of DHFS data from the Family Care Activity Reports, December 2001, February 2002 and March 2002.

Over the course of program implementation, the Resource Centers have generally met or exceeded the DHFS established contract goal of eight contacts per 1,000 target population each month. As presented in ***Exhibit 9***, with the exception of Kenosha and Marathon for the DD population, during the first half of 2001 and 2002, all of the RCs met their contact goals of eight contacts per 1,000 target population. The lower contacts in these two counties may be due in part to the denominator used for the calculations. No direct measure of the number of individuals with developmental disabilities by county exists. Therefore, DHFS used a proxy of the percentage per 1,000 population based on a national average which may not accurately reflect a particular county's population in need. Also worth noting is the lack of the use of media as an outreach avenue in Marathon and the relatively limited use of media in Kenosha in comparison to the other counties with Resource Centers.

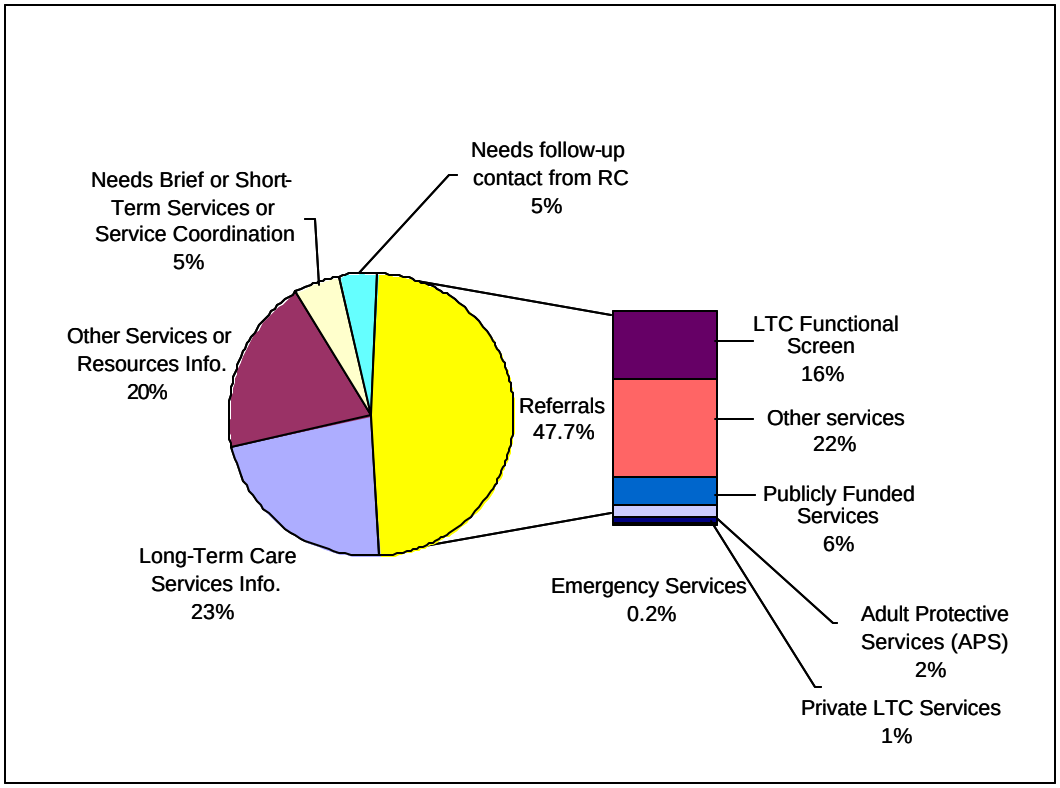
Exhibit 9
RC Contacts per 1,000 per Month
(January to June, 2001 and 2002)



Source: DHFS provided data based on County Resource Center reports.

By targeting non-Medical Assistance (non-MA) eligible individuals, the RCs play a critical role in shifting the point at which individuals receive timely information and potentially enter the service delivery system. Through receiving help with making effective long-term care choices, middle- and upper-income consumers and families may use their private resources more efficiently, thereby reducing the chances of exhausting all their resources and relying on publicly-funded services. No effective data collection means exist to capture the extent to which non-MA individuals use the RC. However, an indication of the breadth of the population using the RCs is that a minority of the contact outcomes focused on access to the COP, HCBS waiver, and CMO benefits. On average 15 percent of all of the RC's contacts were referred for a functional screens for these benefits from January to March 2003, compared to 13 percent for the same period in 2001 (***Exhibit 10***).[6] Also, in the first quarter of 2003, 251 or approximately one percent of RC contacts were referred to private long-term care services and this percentage has been fairly consistent over time.[7] Most consumers requesting information and assistance from the RCs were given information about long-term care services or resources, or referred to services or resources other than emergency, adult protective service, and long-term care.

Exhibit 10
Resource Center Outcomes, First Quarter of 2003



Source: Quarterly Family Care Activity Report: For period January to March 2003.

6 From Quarterly Family Care Activity Report: For periods ending December 2001 and December 2002.

7 From Quarterly Family Care Activity Report: For periods ending March 2003.

D. Health Promotion

RCs provided a range of activities related to health promotion, disease prevention, and safety. Nearly all engaged in vision, blood pressure, hearing, and bone density screenings were common prevention activities occurring at a variety of events, including congregate meals and health care information sessions. Jackson, for example, offered monthly information sessions on topics ranging from nutrition and fitness to the aging process and elder abuse. Richland provided a monthly health bulletin including such topics as macular degeneration and hypothermia / frostbite. Portage offered an 'Ask Your Pharmacist' session during which individuals received information on prescription and over-the-counter medications. In addition, they partnered with the American Red Cross to provide a first-aid seminar, and offered a stroke prevention session.

Similarly, most counties undertook safety promotion and falls prevention initiatives. Portage worked with AARP to offer the '55 Alive' defensive driving course and Marathon partnered with the Neighborhood Watch to educate individuals on crime prevention. Several counties were involved in specific falls prevention initiatives. The 2001 Jackson "Falls Prevention Program" grant led to the development of an exercise group whose members reported increased flexibility and decreased falls. Milwaukee also started several fitness centers through the donation of used gym equipment to prevent falls. Richland provided home safety assessments to identify and remove obstacles leading to falls. Kenosha developed marketing materials for a Falls Prevention Study including a Falls Prevention Study flyer, a letter of intent to medical professionals, and an article for media submission.

E. Quality Assurance/Improvement

Pilot counties have the responsibility to provide quality, culturally competent services and monitor the quality of care at the RCs and the CMOs. DHFS continues to encourage the pilots to oversee quality of the Family Care program locally, but offers many opportunities for the RCs to exchange information and state staff are available for technical assistance. Each RC and CMO must submit a quality plan to the DHFS for approval. The RC must inform people of their rights and responsibilities in ways that they can understand and use, implement a written due process procedure for the review and resolution of complaints and grievances that is consistent with applicable administrative rules set by DHFS, and link clients with advocacy resources. The counties update DHFS regularly through quarterly narrative reports, complaint and grievance reports, and through data reporting. They also participate in workgroups sponsored by DHFS that allow exchange of information and ideas around incorporating components of quality information technology, disability benefit specialists, and other implementation issues.

F. Information Technology

RCs are required to have IT systems that can: 1) track RC contacts, program and service information, referrals, and outcome activities; and 2) support the functional screen automated system used for making level of care determinations. IT systems continue to evolve to support RC functions. Each county has taken its own approach to developing IT systems that support the Family Care model. The use of different systems makes instituting new automation

requirements and integration across systems challenging. ***Exhibit 11*** shows the current status of automation and integration of the major functions for the RCs in the CMO counties.

Exhibit 11
Development of CMO County Resource Center
Information Technology Systems

	I&R and Outcomes	Functional Screens
Fond du Lac	Packaged software (CMHC)	State provided
LaCrosse	County developed – customized software (DRI)	State provided
Milwaukee	County developed – customized software	State provided
Portage	Packaged software (IRIS)	State provided
Richland	Packaged software (IRIS)	State provided

Source: **DHFS provided information and site visit interviews.**

The main RC functions, information and referral, outcome tracking and conducting functional screens have all been computerized. The Resource Centers either added to information and referral software they had in place prior to Family Care or purchased software from vendors designed specifically for this activity. The state provided the functional screen software application because it generates the level-of-care determination required for the MA waiver eligibility, which must be applied uniformly across the state.

G. RC Funding/Budgeting

County RCs receive an annual budget from the DHFS based on the size of the county's target population. Many of the counties provide in-kind support for the RCs through space in county buildings and IT support. ***Exhibit 12*** displays RC start-up funding. ***Exhibit 13*** shows over three-quarters of funding pays staff salaries, and 10 percent covers supplies. In 2001, only one percent of funds were devoted to information technology, down from the percent in 2000 when the RCs were still developing systems. ***Exhibit 14*** details expenditures as reported by the RCs. In 2000, six of the nine RCs relied only on contract dollars to fund the Resource Center. Kenosha, Milwaukee, and Portage reported using other funds to finance personnel, telephone, supplies, IT, education and outreach, and contractual**.** The three RCs reporting other funding sources were those counties that based their operation in the aging network. Actual amount of other funds used are listed in ***Appendix D*****.**

In 2001, the RCs unanimously indicated that the funding levels were inadequate given the scope of requirements in their contracts. A DHFS workgroup examined and developed workload estimates for each RC activity. These workload estimates were the basis for the legislature's RC funding levels. The majority of Resource Center funds come from state general purpose revenue (GPR). However, RCs could collect federal funds for the information and assistance (I&A) function during CY 2000 based on a county specific formula estimating the percentage of MA eligibles per population for whom they provided I & A. The RCs in CMO counties had an additional source of funds available in CY 2001 in the form of Medicaid reimbursement for

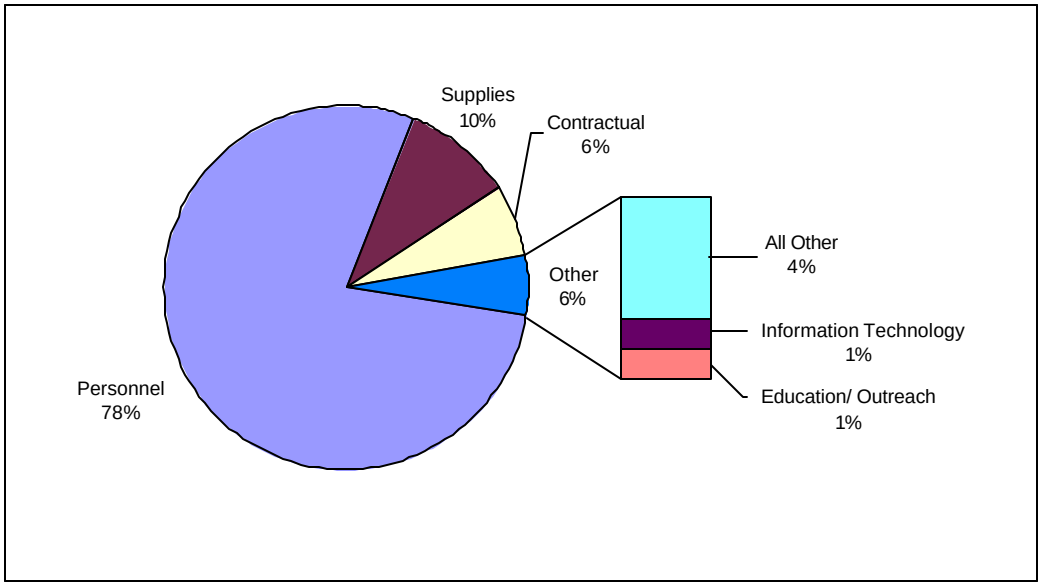
administering the functional screen to determine programmatic eligibility. They can collect funds for each screen performed, not just for MA eligibles, since it is considered an eligibility function.

Exhibit 12
Resource Center Start-Up Funding

COUNTY	RC Planning Grant 1/98- 12/98	RC Planning & Implement Grant 1/99- 12/99	RC Start Up Grant 1/00- 12/00	RC Contract 1/00 – 12/00	Total RC Funding
Funding Source	*#1310, from COP lapse funds*	*#1310 for Jan-June, Budget bill for July-Dec (reallocated)*	*Budget Bill (reallocated funds)*	*Budget Bill (reallocated funds)*	
Fond du Lac	$104,000	$251,883	NA	$432,097	$787,980
Jackson	$45,471	$60,911	NA	$317,598	$423,980
Kenosha	$201,306	$324,195	NA	$727,139	$1,252,640
LaCrosse	$105,044	$280,505	NA	$614,525	$1,000,074
Marathon	$147,513	$330,253	NA	$1,198,385	$1,676,151
Milwaukee	$255,000	$503,681	NA	$1,590,308	$2,348,989
Oneida Tribe	$20,000	NA	NA	NA	$20,000
Portage	$78,000	$112,958	NA	$318,398	$509,356
Richland	NA	$9,989	$101,452	NA	$111,441
Trempealeau	$55,366	$95,324	NA	$290,349	$441,039
TOTALS	**$1,011,700**	**$1,969,699**	**$101,452**	**$5,488,799**	**$8,571,650**

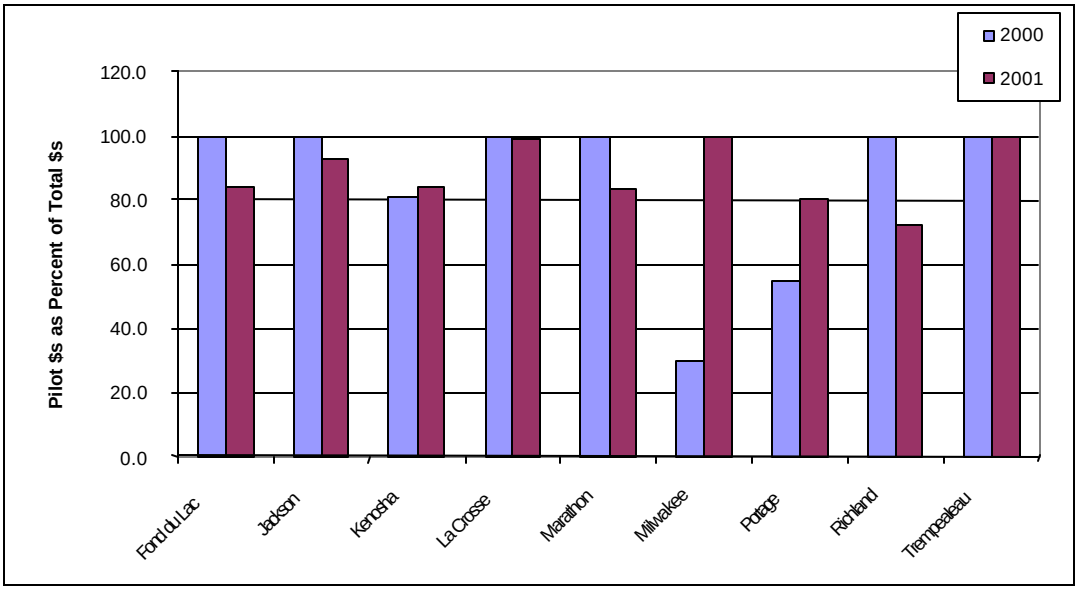
Source: **Information provided to The Lewin Group by the DHFS Policy Monitor and Grant Specialist.**

Exhibit 13
Resource Center Funding by Category of Expense, 2001



Source: RC expenditure report, 2001.

Exhibit 14
Pilot funds as Percent of RC Total Expenditures



Source: RC expenditure report, 2000 and 2001.

SUMMARY

As noted earlier, Aging and Disability Resource Centers (RC) play a critical role for long-term care information and service seekers. Among the nine counties with RCs, all provide, information, assistance and options counseling, while the five CMO counties are also involved in outreach and intake related to the CMO benefit.

The Resource Centers appear to have increased access to information to the target populations. Prior to Family Care, most of the nine counties lacked a centralized source of information regarding long term care services available and options for meeting need. Today, the Resource Centers coordinate information for the three target groups (except in Milwaukee where the focus is only older adults) and actively conduct outreach through a variety of mechanisms. The outreach activities have moved beyond the traditional approach of creating informational brochures and distributing them at community presentations and health fairs to encompass additional distribution avenues, such as Web sites and gatekeepers (e.g., groceries, pharmacies and paramedics), media, including radio and television, and targeted outreach to specific communities (Hmong, children entering the adult system, providers, and rural areas). In The Lewin Group's evaluation of the Family Care program, the measures used to assess the degree of access to information were: 1) the range of outreach activities the Resource Centers pursued; and 2) the number of contacts per capita for each of the target populations relative to DHFS established standards. Both measures indicated RC success.

The evaluation report concluded that the keys to the pilots' success included:

- **Commitment** – The state and the county staff demonstrated a high level of personal investment and pride in the program. They are committed to its success and do not even consider the possibility of reverting back to the old system because they see the advantages of the new system. It is this commitment that motivated the continuous learning process and spirit of cooperation. The current CMO staff and DHFS support the expansion of Family Care because they think it will provide other counties the opportunity to improve their long-term care systems.
- **Cooperation** – All of the parties involved have been willing to work through problems and cooperate to build the new program. Not everyone agrees on everything, but cooperation is evident in: 1) the work groups established by DHFS where counties share information and bring up issues with the state staff; 2) the governing bodies, LTC councils and work groups established at the state and county level to advise on operations and policy; 3) the inter-departmental cooperation between DHFS and the Department of Workforce Development at the state level and the RCs, CMOs and the Economic Support Units at the county level to resolve the eligibility processes; and 4) the advocacy groups' efforts to improve the program and keep everyone focused on the member.
- **Trust** – State staff had to trust the competency of county staff to implement the program. County staff had to trust that the state staff would support them and work with them. Members had to trust that they would continue to receive high quality, appropriate services. The pilots tread in uncharted territory. During one of our site visits, a CMO director commented "We didn't know what we didn't know." As a result, all parties had to have sufficient trust and willingness to make mistakes and learn from them without finger pointing.

The Family Care Web site offers a wealth of information (http://www.dhfs.state.wi.us/LTCare/INDEX.HTM), including the three implementation reports and the final evaluation report The Lewin Group prepared about the program:

First Implementation Report 2000, http://www.legis.state.wi.us/lab/reports/00-0famcaretear.htm

Second Implementation Report 2001, http://www.legis.state.wi.us/lab/Reports/01-0FamilyCare.htm

Third Implementation Report 2002, http://www.dhfs.state.wi.us/LTCare/ResearchReports/LewinEval3Summary.HTM

Final Evaluation Report 2003, http://www.legis.state.wi.us/lab/reports/03-0FamilyCare.pdf

The Department of Health and Family Services Response to the Final Report, http://www.dhfs.state.wi.us/LTCare/ResearchReports/DHFSResponsetoLewinRpt.pdf.

Appendix A

MAJOR LONG TERM CARE FUNDING SOURCES IN WISCONSIN

COP-R: The Community Options Program, monitored by the Department of Health and Family Services, is administered by local county agencies to deliver community-based services to Wisconsin citizens in need of long term assistance. Any person regardless of age, with nursing home level of care is eligible for COP. The program began as a demonstration in eight counties in 1982 and was expanded statewide in 1986.

COP-W: The Community Options Program Waiver provides Medical Assistance funding for home and community-based care for elderly and physically disabled citizens who have long-term care needs and who would otherwise be eligible for Medical Assistance reimbursement in a nursing home. County participation was mandated effective January 1, 1990.

CIP IA: The Community Integration Program IA is a Medical Assistance funded program to provide community services to persons who are relocated from the State Centers for the Developmentally Disabled. County participation was mandated effective January 1, 1996.

CIP 1B: The Community Integration Program IB is a Medical Assistance funded program to provide community services to persons with developmental disabilities who are relocated or diverted from nursing homes and Intermediate Care Facilities-Mental Retardation (ICFs-MR) other than the State Centers for the Developmentally Disabled. County participation was mandated effective January 1, 1996.

CIP II: The Community Integration Program II is a Medical Assistance funded program to provide community services to elderly and physically disabled persons after a nursing home bed is closed. County participation was mandated effective January 1, 1990[8]

Medical Assistance Card: Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for healthcare services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements. Wisconsin Medicaid is administered by the Department of Health and Family Services (DHFS), Division of Health Care Financing (DHCF). Wisconsin Medicaid covers a broad range of health care services, including home health and nursing facility care as well as the personal care option. However, limitations apply that are designed to ensure the provision of only medically necessary services.[9]

Older Americans Act: Since 1965, the Older Americans Act (the Act) has gained recognition as a unique and highly regarded statute that has contributed greatly to enhancement of the lives of people 60 years and older. State Agencies on Aging receive Title III funds, which are made available to the States on a formula basis upon approval of State Plans by the AoA Regional Offices. States then allocate funds to the Area Agencies on Aging, based on approved Area Plans. The Older Americans Act supports the elderly nutrition program and meals-on-wheels, the county and area offices on aging, and the benefit specialists. The Act also supports nursing home ombudsman and elder abuse prevention, as well as up to 85 percent of the costs of supportive services, senior centers, and nutrition services.[10]

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8 Adapted from www.dhfs.state.wi.us.

9 Adapted from www.cms.gov.

10 www.aoa.dhhs.gov

Appendix B

Exhibit B-1
Resource Center Staffing of Full Time Employees
March 2001 and March 2002 (FTEs)

RC Position	Fond du Lac		Jackson		Kenosha		La Crosse		Marathon		Milwaukee		Portage		Richland		Trempealeau	
	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02
Agency Director													0.25	0.25		0.30		
RC Manager	1.00	1.00	0.57	0.57	1.50	1.50	0.75	1.00	1.00	1.00	1.00	1.00	0.75	0.68	0.50	1.00	1.00[a]	1.00[a]
Supervisor								1.00			4.25	5.25						
I and A	2.25	3.25	0.50[a]	0.50	4.10	5.18	1.75	2.00	6.00	7.00	9.00	10.00	3.75[a]		1.50[a]	2.00[a]	.50	.50
Screener (non RN)	4.25	2.50	0.50	0.50	6.10	5.95	4.50	6.00	5.00	5.00	25.00	25.00		3.00			0.50	0.50
Screener (RN)					1.00	1.00	1.00	1.00	1.00	2.00	1.00	1.00		1.00	0.25			
Nurse	0.30	0.30													0.25	0.50		0.20
Disability Benefit Specialist	0.25	0.75	0.45	0.70	1.00	1.00	0.50	1.00		1.00	[c]		0.25	1.00		0.60	0.25	0.50
Support Staff			0.50	0.50						1.60		3.50	0.58	0.68	0.50	1.00		
Quality Coordinator											1.00	1.00						
Enrollment/Brief Services											3.00	13.00						
Outreach Specialist						1.00					1.00	2.00						
Social Service Specialist	3.75	3.25									10.00	5.00						
Case Manager					0.05[b]	0.05												
Total	11.80	11.05	2.52	2.77	13.75	15.68	8.50	12.00	13.00	17.60	55.25	66.75	5.58	6.61	3.00	5.40	2.25	2.70

[a] These individuals also perform screening.

[b] Kenosha uses case managers to complete screens on existing cases.

[c] Milwaukee is not required to have a disability benefit specialist because the RC focuses exclusively on the elderly, and there is already a well-established elderly benefit specialist program throughout the state.

Note: Kenosha's numbers from 2001 were updated from 2001 report to correct errors.

Source: Resource Center 1st Quarter 2001 and 2002 Reports provided to The Lewin Group by DHFS and correspondence with county staff.

Appendix C

DISABILITY BENEFIT SPECIALIST

The Disability Benefit Specialist is a highly specialized position. Benefit specialists are continually trained and monitored by attorneys knowledgeable in elderly or disability law. The specialist can consult with this legal back-up to determine appropriate interpretation of the law. The disability benefit specialist has three main functions that differentiate their duties from that of a case manager or social worker experienced with the target populations. The functions are as follows:

1. Information about available benefits;
2. Assistance to apply for benefits; and
3. Advocacy for appealing benefits denial.

Qualifications:

- Bachelor's degree in human service field
- Previous direct or related experience (1 year)
- Flexibility in scheduling
- Access to reliable transportation with required insurance coverage for daily use
- Well developed oral and written communication skills
- Ability to work in a team setting
- Ability to assist individuals to coordinate effective personal planning and assist individuals in following through with the plan
- Job Skills:
- Provide technical assistance to consumers about how to access benefits
- Assist in organizing and verifying both financial and non-financial data to apply for benefits
- Assist individuals in coordinating effective personal planning and assist individuals in following through with the plan
- Provide accurate and current information about the following benefits:
  - ➢ Medicare
  - ➢ Medicare supplement insurance
  - ➢ Supplemental Security Income (SSI)
  - ➢ Social Security
  - ➢ Medical Assistance
  - ➢ Consumer problems
  - ➢ Age discrimination in employment
  - ➢ Homestead Tax Credit
  - ➢ Housing problems

  - ➢ Supportive home services
  - ➢ Food Stamps
  - ➢ Veteran's Administration benefits
  - ➢ General Relief
  - ➢ Other legal and benefit problems
- Consult with legal back-up to determine appropriate interpretation of law or regulation and appropriate action to assist in resolution of concerns
- Refer to legal back-up for consideration of representation in judicial proceeding
- Initiate investigations to gather needed factual information to pursue advocacy duties
- Provide information on consumer rights, complaint, grievance and appeals processes
- Provide advice and assistance in preparing and filing complaints, grievances, and appeals at the local and state levels, as well as beyond
- Provide representation for consumers, as needed in administrative hearings, as well as in other formal or informal grievance set-ups
- Provide technical assistance in completing reporting activities and appeal procedures on behalf of the individuals who have been denied benefits
- Negotiate on behalf of individuals with service providers, or the District regarding disputes over long-term care services
- Make appropriate referrals for employment and other disability related counseling and services
- Identify concerns and problems of people with disabilities and related system level issues, as appropriate, and present that information to appropriate entities
- Provide consumer and volunteer training and technical assistance to develop self and family advocacy

Appendix D

Exhibit D-1
Resource Center Total Expenditures (Percent of Pilot Dollars Used)

	Fond du Lac		Jackson		Kenosha	
	2000	2001	2000	2001	2000	2001
Personnel	$429,303 (100%)	$680,140 (82.5%)	$64,518 (100%)	$83,166 (100%)	$418,306 (78.6%)	$574,037 (79.6%)
Telephone	$5,135 (100%)	$6,163 (100%)	$2,503 (100%)		$28,058 (88.4%)	$27,921 (100%)
Supplies	$3,864 (100%)	$1,610 (100%)	$1,055 (100%)	$2,496 (100%)	$1,42 (93.7%)	$1,602 (100%)
IT		$15,149 (100%)	$5,578 (100%)	$384 (100%)	$44,874 (93.1%)	$13,197 (100%)
Education / Outreach	$1,981 (100%)	$750 (100%)	$20,242 (100%)	$10,321 (100%)	$15,077 (89.8%)	$11,184 (100%)
Contractual	$298 (100%)	$8,622 (100%)	$10,434 (100%)	$8,050 (100%)	$63,206 (77.5%)	$71,884 (100%)
Brief Services			$15,881 (100%)	$62,703 (79.5%)		
All Other	$2,373 (100%)	$37,244 (100%)	$120,210 (100%)	$23,913 (100%)	$33,322 (95.3%)	$35,434 (100%)
Total	$442,954 (100%)	$749,678 (84.1%)	$240,421 (100%)	$191,032 (93.3%)	$604,266 (81.2%)	$735,258 (84.1%)

	La Crosse		Marathon		Milwaukee	
	2000	2001	2000	2001	2000	2001
Personnel	$277,216 (100%)	$349,140 (98.9%)	$390,662 (100%)	$597,094 (71.2%)	$2,887,320 (35.9%)	$3,749,909 (100%)
Functional Screen						
Telephone	$4,584 (100%)	$70,816 (100%)	$5,430 (100%)	$2,927 (100%)	$7,819 (0.0%)	
Supplies	$18,112 (100%)		$34,661 (100%)	$10,864 (100%)	$111,615 (0.0%)	$694,853 (100%)
IT	$6,596 (100%)	$12,440 (100%)	$30,521 (100%)	$28,650 (78.8%)	$180,206 (0.0%)	
Education/Outreach	$5,250 (100%)		$91,338 (100%)	$40,850 (100%)	$58,820 (0.0%)	
Contractual		$28,726 (100%)	$298,006 (100%)	$390,316 (100%)	$41,331 (0.0%)	
Brief Services	$153,140 (100%)	$97,596 (100%)				$1,047 (100%)
All Other	$464,898 (100%)	$558,717 (99.3%)	$36,663 (100%)		$170,958 (0.0%)	
Total	$277,216 (100%)	$349,140 (98.9%)	$887,281 (100%)	**$1,070,701** (83.4%)	$3,458,069 3(0.0%)	**$4,445,809** (100%)

	Portage		Richland		Trempealeau	
	2000	2001	2000	2001	2000	2001
Personnel	$371,932 (42.0%)	$266,878 (77.4%)	$44,205 (100%)	$174,001 (72.0%)	$96,114 (100%)	$120,810 (100%)
Functional Screen						
Telephone	$3,206 (100%)		$3,254 (100%)	$8,508 (72.0%)	$1,485 (100%)	$1,733 (100%)
Supplies	$5,627 (100%)	$35,022 (98.8%)	$2,472 (100%)		$3,550 (100%)	$2,037 (100%)
IT	$54,199 (100%)		$33,413 (100%)		$5,732 (100%)	
Education/Outreach	$15,00 (100%)		$4,776 (100%)		$16,679 (100%)	
Contractual	$3,000 (100%)				$4,305 (100%)	
Brief Services		$2,577 (22.5%)		$6,031 (74.6%)		
All Other	$22,337 (100%)	$23,856 (98.9%)	$13,336 (100%)	$188,540 (72.1%)	$6,390 (100%)	$71,393 (100%)
Total	$475,355 (54.6%)	**$328,333** (80.8%)	$101,453 (100%)		$134,254 (100%)	**$235,378** (100%)